

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036327</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																	
Facility Name: <u>Ellner Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/01</u> to <u>06/30/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																	
Address: <u>Market & Columbia Streets</u> <u>Evansville</u> <u>62242</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																	
County: <u>Randolph</u>																			
Telephone Number: <u>(618) 853-4451</u> Fax # <u>(618) 853-2555</u>																			
IDPA ID Number: <u>363234108004</u>																			
Date of Initial License for Current Owners: <u>06/01/90</u>																			
Type of Ownership:																			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT																			
<input checked="" type="checkbox"/> Charitable Corp.																			
<input type="checkbox"/> Trust																			
IRS Exemption Code <u>501 (c)(3)</u>																			
<input type="checkbox"/> PROPRIETARY																			
<input type="checkbox"/> Individual																			
<input type="checkbox"/> Partnership																			
<input type="checkbox"/> Corporation																			
<input type="checkbox"/> "Sub-S" Corp.																			
<input type="checkbox"/> Limited Liability Co.																			
<input type="checkbox"/> Trust																			
<input type="checkbox"/> Other																			
<input type="checkbox"/> GOVERNMENTAL																			
<input type="checkbox"/> State																			
<input type="checkbox"/> County																			
<input type="checkbox"/> Other																			
In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page		<table border="1"> <tr> <td rowspan="2"> Officer or Administrator of Provider </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4"> Paid Preparer </td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Officer or Administrator of Provider	(Signed) _____																		
	(Date) _____																		
Paid Preparer	(Type or Print Name) _____																		
	(Title) _____																		
	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>																		
	(Date) _____																		
	(Print Name and Title) _____																		
	(Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>																		
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MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Ellner Terrace# 0036327 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,341</u>			<u>5,341</u>	13
14	TOTALS	<u>5,341</u>			<u>5,341</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.46%

D. How many bed-hold days during this year were paid by Public Aid?

97 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/01/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 06/01/90NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified 0 and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Ellner Terrace # 0036327 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	16,429	1,118	2,002	19,549		19,549		19,549		1
2	Food Purchase		25,541		25,541		25,541	(3,271)	22,270		2
3	Housekeeping		1,427		1,427		1,427		1,427		3
4	Laundry		1,686		1,686		1,686		1,686		4
5	Heat and Other Utilities			9,669	9,669		9,669		9,669		5
6	Maintenance	9,943		6,962	16,905		16,905		16,905		6
7	Other (specify):*										7
8	TOTAL General Services	26,372	29,772	18,633	74,777		74,777	(3,271)	71,506		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	148,771	3,722	2,688	155,181		155,181		155,181		10
10a	Therapy			64	64		64		64		10a
11	Activities		3,472		3,472		3,472		3,472		11
12	Social Services			2,531	2,531		2,531		2,531		12
13	Nurse Aide Training	3,100		6,505	9,605		9,605		9,605		13
14	Program Transportation			2,331	2,331		2,331		2,331		14
15	Other (specify):* Routine Dental			1,193	1,193		1,193		1,193		15
16	TOTAL Health Care and Programs	151,871	7,194	16,512	175,577		175,577		175,577		16
	C. General Administration										
17	Administrative	16,821		68,400	85,221		85,221		85,221		17
18	Directors Fees							2,959	2,959		18
19	Professional Services			868	868		868	7,091	7,959		19
20	Dues, Fees, Subscriptions & Promotions			2,310	2,310		2,310	115	2,425		20
21	Clerical & General Office Expenses		1,813	6,495	8,308		8,308	3,199	11,507		21
22	Employee Benefits & Payroll Taxes			26,776	26,776		26,776	14,553	41,329		22
23	Inservice Training & Education			454	454		454		454		23
24	Travel and Seminar			2,718	2,718		2,718	275	2,993		24
25	Other Admin. Staff Transportation			562	562		562	253	815		25
26	Insurance-Prop.Liab.Malpractice			141	141		141	4,598	4,739		26
27	Other (specify):*										27
28	TOTAL General Administration	16,821	1,813	108,724	127,358		127,358	33,043	160,401		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	195,064	38,779	143,869	377,712		377,712	29,772	407,484		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			4,716	4,716		4,716	259	4,975			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			565	565		565	2,064	2,629			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			69,255	69,255		69,255		69,255			34
35	Rent-Equipment & Vehicles			2,875	2,875		2,875	11	2,886			35
36	Other (specify):*											36
37	TOTAL Ownership			77,411	77,411		77,411	2,334	79,745			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			783	783		783	444	1,227			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			22,943	22,943		22,943	8,405	31,348			42
43	Other (specify):* Nonallowable Costs			145,977	145,977		145,977	(145,977)				43
44	TOTAL Special Cost Centers			169,703	169,703		169,703	(137,128)	32,575			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	195,064	38,779	390,983	624,826		624,826	(105,022)	519,804			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

0036327

Report Period Beginning:

07/01/01

Ending:

06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care	\$	\$	1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs	(143,172)	43	3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms	(431)	43	5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation			9
10	Interest and Other Investment Income	(813)	32	10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax			13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties	(2,264)	43	18
19	Entertainment			19
20	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt			24
25	Fund Raising, Advertising and Promotional	(110)	43	25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,790)	\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	41,768	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 41,768	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (105,022)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X	\$		38
39					39
40	Gift and Coffee Shops	X			40
41	Barber and Beauty Shops	X			41
42	Laboratory and Radiology	X			42
43	Prescription Drugs	X			43
44	Exceptional Care Program	X			44
45	Other-Attach Schedule	X			45
46	Other-Attach Schedule	X			46
47	TOTAL (C): (sum of lines 38-46)		\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Ellner Terrace

ID# 0036327

Report Period Beginning: 07/01/01

Ending: 06/30/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/02

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ellner Terrace

0036327

Report Period Beginning:

07/01/01

Ending:

06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	259	0	0	0	0	0	0	0	0	0	259	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(813)	288	2,589	0	0	0	0	0	0	0	0	2,064	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	11	0	0	0	0	0	0	0	0	0	11	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(813)	558	2,589	0	0	0	0	0	0	0	0	2,334	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	444	0	0	0	0	0	0	0	0	0	444	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	8,405	0	0	0	0	0	0	0	0	8,405	42
43	Other (specify):*	(145,977)	0	0	0	0	0	0	0	0	0	0	(145,977)	43
44	TOTAL Special Cost Centers	(145,977)	444	8,405	0	0	0	0	0	0	0	0	(137,128)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(146,790)	13,115	28,653	0	0	0	0	0	0	0	0	(105,022)	45

Facility Name & ID Number Ellner Terrace

0036327

Report Period Beginning:

07/01/01

Ending:

06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Centers, Inc. - See attached Schedule 7A	100%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	18 Board fees	\$	Center for Residential Management, Inc.	**	\$ 953	\$ 953 1
2	V	19 Professional fees		Center for Residential Management, Inc.	**	2,354	2,354 2
3	V	20 Licenses, dues, & subs		Center for Residential Management, Inc.	**	64	64 3
4	V	21 Office supplies & telephone		Center for Residential Management, Inc.	**	2,837	2,837 4
5	V	22 Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	5,552	5,552 5
6	V	24 Travel & seminar		Center for Residential Management, Inc.	**	62	62 6
7	V	25 Vehicle expense		Center for Residential Management, Inc.	**	253	253 7
8	V	26 Vehicle, fire & liab insurance		Center for Residential Management, Inc.	**	38	38 8
9	V	30 Depreciation		Center for Residential Management, Inc.	**	259	259 9
10	V	32 Interest expense		Center for Residential Management, Inc.	**	288	288 10
11	V	35 Vehicle lease		Center for Residential Management, Inc.	**	11	11 11
12	V	39 Ancillary service centers		Center for Residential Management, Inc.	**	444	444 12
13	V				**		13
14	Total		\$			\$ 13,115	\$ * 13,115 14

** Center for Residential Management, Inc. is Residential Centers, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule VII - Related Parties**Page 6, Section A, Column 2, Related Nursing Homes****Related Party Schedule**

<u>Name</u>	<u>Facility Name</u>	<u>City</u>
Progressive Housing, Inc.	Gateway Terrace	Irvington
	Aviston Terrace	Aviston
	Briarbrook Place	East Peoria
	Joshua Manor	Hoyleton
	Terra Estates	Hoyleton
	Park Place	Pana
	Harris Place	East Peoria
	Okawville	Okawville
	Billy Goat Hill	Mt. Vernon
	Country Club Hills (185th St.)	Country Club Hills
	Country Club Hills (Lee St.)	Country Club Hills
	Galaxy	Woodlawn
	Perrine	Centralia
	Troy	Troy
	Western Gardens	Mt. Vernon
	Cardinal	Woodlawn
Residential Centers, Inc.	Lakeview Living Center	Chicago
	Countryview Living Center	Latham
	Sparta Terrace	Sparta
	Taylorville Terrace	Taylorville
	Ellner Terrace	Evansville
Caravilla Resident Centers, Inc.	Mt. Vernon Care Center	Mt. Vernon
	Jeffersonian Care Center	Mt. Vernon
	Casey Care Center	Mt. Vernon

Schedule VII, Related Parties**Page 6, Section A, Column 3, Other Related Business Entities**

<u>Name</u>	<u>City</u>	<u>Type of Business</u>
Center for Residential Management, Inc.	Peoria	Management/Holding Co.
Residential Centers, Inc.	Peoria	ICF/DD Provider
Progressive Housing, Inc.	Peoria	ICF/DD Provider
Caravilla Charitable Corporation	Mt. Vernon	Lessor
Caravilla Resident Centers, Inc.	Mt. Vernon	SNF/ICF Provider

See Accountants' Compilation Report

Facility Name & ID Number Ellner Terrace

0036327

Report Period Beginning: 07/01/01

Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	18 Board fees	\$	Residential Centers, Inc.	100.00%	\$ 2,006	\$ 2,006	15
16	V	19 Professional fees		Residential Centers, Inc.	100.00%	4,737	4,737	16
17	V	20 License, dues & subscriptions		Residential Centers, Inc.	100.00%	2	2	17
18	V	21 Office supplies & telephone		Residential Centers, Inc.	100.00%	362	362	18
19	V	22 Emp. benefits & payroll taxes		Residential Centers, Inc.	100.00%	5,779	5,779	19
20	V	24 Travel & seminar		Residential Centers, Inc.	100.00%	213	213	20
21	V	26 Vehicle, fire & liab insurance		Residential Centers, Inc.	100.00%	4,560	4,560	21
22	V	32 Interest expense		Residential Centers, Inc.	100.00%	2,589	2,589	22
23	V	42 Provider fees		Residential Centers, Inc.	100.00%	8,405	8,405	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 28,653	\$ * 28,653	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0036327 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ronald Schroeder	President	Board Member	None	14,827	2 hrs/mtg.		Directors Fees	\$ 573	L18, C8	1
2	Darrell Boehne	Vice President	Board Member	None	14,844	2 hrs/mtg.		Directors Fees	556	L18, C8	2
3	Edward Childers	Secretary	Board Member	None	14,639	2 hrs/mtg.		Directors Fees	561	L18, C8	3
4	Robert Bauer	Treasurer	Board Member	None	13,444	2 hrs/mtg.		Directors Fees	556	L18, C8	4
5	Merla McCloud	Recorder	Administrative	None	17,844	2 hrs/mtg.		Directors Fees	556	L18, C8	5
6	Orland Bauer	Director	Board Member	None	10,243	2 hrs/mtg.		Directors Fees	157	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12	See attached Schedule 7A										12
13								TOTAL	\$ 2,959		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

SCHEDULE 7A

Board of Directors Fees

	Ron <u>Schroeder</u>	Darrell <u>Boehne</u>	Edward <u>Childers</u>	Bob <u>Bauer</u>	Cora <u>Flota</u>	Orland <u>Bauer</u>	Kay Schuman <u>Johnson</u>	Roger <u>Ryan</u>	Ronald <u>O'Daniell</u>	William <u>Armstrong</u>	Kay <u>Baker</u>	Merla <u>McCloud</u>	Totals
Residential Centers, Inc.													
Lakeview Living Center	3,757	3,606	3,606	3,606								3,606	18,181
Sparta Terrace	415	398	398	398								398	2,006
Ellner Terrace	415	398	398	398								398	2,006
Taylorville Terrace	415	398	398	398								398	2,006
Total RCI	5,000	4,800	4,800	4,800	0	0	0	0	0	0	0	4,800	24,200
Progressive Housing, Inc.													
Aviston Terrace	553	576	553		553	553	282					553	3,623
Harris Place	553	576	553		553	553	282					553	3,623
Briarbrook Place	553	576	553		553	553	282					553	3,623
Joshua Manor	553	576	553		553	553	282					553	3,623
Terra Estates	553	576	553		553	553	282					553	3,623
Park Place	553	576	553		553	553	282					553	3,623
Okawville	207	216	207		207	207	106					207	1,358
Perrine	138	144	138		138	138	71					138	906
Western Gardens	138	144	138		138	138	71					138	905
Galaxy	276	288	276		276	276	141					276	1,811
Billy Goat Hill	276	288	276		276	276	141					276	1,811
Troy	138	144	138		138	138	71					138	906
Country Club Hills - 185th St.	207	216	207		207	207	106					207	1,357
Country Club Hills - Lee St.	101	101	101		101	101	0					101	608
Total PHI	4,800	5,000	4,800	0	4,800	4,800	2,400	0	0	0	0	4,800	31,400
Caravilla Resident Centers, Inc.													
Mt. Vernon				980				871	871	871	871	871	5,338
Jeffersonian Care Center				996				885	885	885	885	885	5,421
Casey Care Center				1,624				1,443	1,443	1,443	1,443	1,443	8,841
Total CRC	0	0	0	3,600	0	0	0	3,200	3,200	3,200	3,200	3,200	19,600
Center for Residential Management, Inc. *													
	5,600	5,600	5,600	5,600		5,600						5,600	33,600
Total Board of Directors Fees	15,400	15,400	15,200	14,000	4,800	10,400	2,400	3,200	3,200	3,200	3,200	18,400	108,800

* Center for Residential Management, Inc.'s board fees are allocated to each facility.

Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions with the nursing home during the reporting period.

See Accountants' Compilation Report

Facility Name & ID Number Ellner Terrace# 0036327Report Period Beginning: 07/01/01Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Center for Residential Management, Inc.
 Street Address 4239 W. War Memorial Dr., Suite 302
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed days available	21	\$ 7,680	\$	5,840	\$ 216	1
2	20	Licenses, dues, & subs	Bed days available	21	(100)		5,840	(3)	2
3	21	Office supplies & telephone	Bed days available	21	(861)		5,840	(25)	3
4	24	Travel & seminar	Bed days available	21	(580)		5,840	(17)	4
5	25	Vehicle expense	Bed days available	21	8,145		5,840	229	5
6	26	Vehicle, fire & liab insurance	Bed days available	21	1,353		5,840	38	6
7	30	Depreciation	Bed days available	21	9,194		5,840	259	7
8	32	Interest expense	Bed days available	21	8,154		5,840	229	8
9	35	Vehicle lease	Bed days available	21	375		5,840	11	9
10	39	Ancillary service centers	Bed days available	21	15,783		5,840	444	10
11									11
12									12
13									13
14									14
15									15
16									16
17	18	Board fees	Direct method					953	17
18	19	Professional fees	Direct method					2,138	18
19	20	Licenses, dues, & subs	Direct method					67	19
20	21	Office supplies & telephone	Direct method					2,862	20
21	22	Emp. benefits & payroll taxes	Direct method					5,552	21
22	24	Travel & seminar	Direct method					79	22
23	25	Vehicle expense	Direct method					24	23
24	32	Interest expense	Direct method					59	24
25	TOTALS				\$ 49,143	\$		\$ 13,115	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace# 0036327

Report Period Beginning:

07/01/01Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Residential Centers, Inc.

Street Address

4239 W. War Memorial Dr., Suite 302

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 685-0595

Fax Number

(309) 685-8463

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	Board fees	Number of beds, direct cost	193	4	\$ 24,199	\$ 16	\$ 2,006	1
2	19	Professional fees	Number of beds, direct cost	193	4	58,219	16	4,737	2
3	20	License, dues & subscriptions	Number of beds	193	4	21	16	2	3
4	21	Office supplies & telephone	Number of beds, direct cost	193	4	7,768	16	362	4
5	22	Emp. benefits & payroll taxes	Number of beds	193	4	2,017	16	167	5
6	24	Travel & seminar	Number of beds	193	4	2,568	16	213	6
7	32	Interest expense	Number of beds, direct cost	193	4	74,026	16	2,589	7
8	42	Provider fees	Number of beds, direct cost	193	4	110,799	16	8,405	8
9									9
10									10
11									11
12									12
13									13
14									14
15	22	Emp. benefits & payroll taxes	Direct method					5,612	15
16	26	Vehicle, fire & liab insurance	Direct method					4,560	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 279,617	\$	\$ 28,653	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0036327 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	NCS Healthcare, Inc.		x	Hardware/Software	\$145.00	10/31/98	\$ 5,783	\$ 2,098	09/30/03	0.1429	\$ 193	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	N/P - IDPA		x	Recoupment of overpayment	varies	07/01/01	7,455	7,420	06/30/03		none	6	
7												7	
8												8	
9	TOTAL Facility Related				\$145.00		\$ 13,238	\$ 9,518			\$ 193	9	
	B. Non-Facility Related*												
10							Miscellaneous interest expense				3,020	10	
11							Offset interest income				(48)	11	
12							Nonallowable interest expense				(765)	12	
13							Parent company allocation				229	13	
14	TOTAL Non-Facility Related										\$ 2,436	14	
15	TOTALS (line 9+line14)						\$ 13,238	\$ 9,518			\$ 2,629	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

	Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$ _____	1
1. Real Estate Tax accrual used on 2001 report.		\$ _____	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ _____	2
3. Under or (over) accrual (line 2 minus line 1).		\$ _____	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ _____	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			
TOTAL REFUND \$	For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ _____	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:								
1997			8			FOR OHF USE ONLY		
1998			9					
1999			10		13	FROM R. E. TAX STATEMENT FOR 2001 \$		13
2000			11		14	PLUS APPEAL COST FROM LINE 5 \$		14
2001			12		15	LESS REFUND FROM LINE 6 \$		15
					16	AMOUNT TO USE FOR RATE CALCULATION \$		16

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ellner Terrace COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0036327

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.			\$	\$
2.	<u>N/A</u>		\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100
 B. General Construction Type: Exterior Wood with Siding
 Frame Wood
 Number of Stories One

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	N/A			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

0036327

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Building Improvements	1994		6,426	428	15	428		3,641
10	Building Improvements	1995		1,301	87	15	87		651
11	Excavating	1996		1,100	73	15	73		428
12	Mixing Valve	1998		659	44	15	44		187
13	Tile	2000		542	54	15	54		105
14	Shower Faucet	2000		747	50	15	50		125
15	Tile	2001		1,289	86	15	86		136
16	Tile	2001		1,219	81	15	81		81
17	Flooring and Trim	2001		1,205	67	15	67		67
18	Shower walls and tile	2001		982	65	15	65		65
19	Shower walls and tile	2001		900	60	15	60		60
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 16,370	\$ 1,095		\$ 1,095	\$	\$ 5,546	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 27,034	\$ 2,713	\$ 2,713	\$	5-10 Years	\$ 15,059	71
72	Current Year Purchases	2,655	68	68		5-10 Years	68	72
73	Fully Depreciated Assets							73
74	Parent company allocation			259	259			74
75	TOTALS	\$ 29,689	\$ 2,781	\$ 3,040	\$ 259		\$ 15,127	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	96 Buick Century Wagon	2002	\$ 3,600	\$ 360	\$ 360	\$	5	\$ 360	76
77	Facility Use	97 Chevy Astro Van	2002	4,800	480	480		5	480	77
78										78
79										79
80	TOTALS			\$ 8,400	\$ 840	\$ 840	\$		\$ 840	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 54,459	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,716	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,975	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 259	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,513	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Community Living Options

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>16</u>	<u>06/01/00</u>	\$ <u>69,255</u>	<u>5</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>16</u>		\$ <u>69,255</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A.

N/A

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: N/A*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 0

Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Resident care</u>	<u>1996 Buick Century</u>	\$ <u>250.00</u>	\$ <u>1,500</u>	17
18	<u>Resident care</u>	<u>1998 Chevy Astro Van</u>	<u>229.00</u>	<u>1,375</u>	18
19					19
20	<u>Parent company allocation</u>			<u>11</u>	20
21	TOTAL		\$ <u>479.00</u>	\$ <u>2,886</u>	21

10. Effective dates of current rental agreement:

Beginning 06/01/00

Ending 05/31/05

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 06/30/2003 \$ 69,255

13. 06/30/2004 \$ 69,255

14. 06/30/2005 \$ 63,484

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3		4	
		Facility							
		Drop-outs	Completed	Contract	Total				
1	Community College Tuition	\$	6,386	\$	6,386				
2	Books and Supplies		119		119				
3	Classroom Wages (a)		3,100		3,100				
4	Clinical Wages (b)								
5	In-House Trainer Wages (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$	9,605	\$	9,605				
10	SUM OF line 9, col. 1 and 2 (e)	\$	9,605						

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A					8	783	444	8	1,227
14	TOTAL			\$		8	\$ 783	\$ 444	8 \$	1,227

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Ellner Terrace
Provider #0036327
6/30/2002

Schedule 16A

XIV. Special Services
Line 13 - Other

Service	Line & Col. Ref.	Units	Cost	Supplies
Emergency Dental	L39, C3	7	748	
Eye Care	L39, C3	1	35	
Part B Medicare Supplies	L39, C8			444
		8	783	444

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Ellner Terrace

0036327

Report Period Beginning: 07/01/01

Ending:

06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/02

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,045	\$ 6,045	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	138,532	138,532	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,275	1,275	6
7	Other Prepaid Expenses	5,109	5,109	7
8	Accounts Receivable (owners or related parties)	113,665	113,665	8
9	Other(specify): See Attached Schedule 17A	58,120	58,120	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 322,746	\$ 322,746	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	16,370	16,370	15
16	Equipment, at Historical Cost	38,089	38,089	16
17	Accumulated Depreciation (book methods)	(21,513)	(21,513)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,946	\$ 32,946	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 355,692	\$ 355,692	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 19,306	\$ 19,306	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,891	12,891	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	55,529	55,529	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 87,726	\$ 87,726	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,518	9,518	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,518	\$ 9,518	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 97,244	\$ 97,244	46
47	TOTAL EQUITY (page 18, line 24)	\$ 258,448	\$ 258,448	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 355,692	\$ 355,692	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Ellner Terrace
Provider #0036327
6/30/2002

XV. Balance Sheet

<u>Line 9 - Other Current Assets</u>	<u>Operating</u>	<u>After Consolidation</u>
Prepaid Deposits	15,000	15,000
Due From Third Party	<u>43,120</u>	<u>43,120</u>
Total	<u>58,120</u>	<u>58,120</u>

<u>Line 36 - Other Current Liabilities</u>		
Accrued Expense	9,866	9,866
Accrued Workshop	43,120	43,120
Resident Credit Balances	1,943	1,943
Accrued Insurance Payable	<u>600</u>	<u>600</u>
	<u>55,529</u>	<u>55,529</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 181,047	1
2	Restatements (describe):		2
3	Prior period audit adjustments	36,736	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 217,783	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	81,052	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Parent company allocation	(40,387)	15
16	Other (describe) (added back in column 7)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 40,665	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 258,448	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Ellner Terrace

0036327

Report Period Beginning: 07/01/01

Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 558,314	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 558,314	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	143,172	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,344	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 147,516	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 705,878	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	74,777	31
32	Health Care	175,577	32
33	General Administration	127,358	33
B. Capital Expense			
34	Ownership	77,411	34
C. Ancillary Expense			
35	Special Cost Centers	146,760	35
36	Provider Participation Fee	22,943	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 624,826	40
41	Income before Income Taxes (line 30 minus line 40)**	81,052	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 81,052	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
A federal tax return is filed for the combined divisions of Residential Centers, Inc.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Ellner Terrace

0036327

Report Period Beginning: 07/01/01

Ending:

06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	628	676	10,140	15.00	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	360	360	3,100	8.61	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,850	2,006	16,429	8.19	15
16	Dishwashers					16
17	Maintenance Workers	913	1,146	9,943	8.68	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	830	967	16,821	17.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,498	1,560	20,982	13.45	29
30	Habilitation Aides (DD Homes)	14,222	15,268	117,649	7.71	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,301	21,983	\$ 195,064 *	\$ 8.87	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	30	\$ 1,987	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	123	L10, C3	39
40	Physical Therapy Consultant	1	34	L10a, C3	40
41	Occupational Therapy Consultant	1	30	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	49	2,531	L12, C3	45
46	Other(specify)				46
47	Psychological Consultant	Monthly	2,565	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	81	\$ 8,470		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description		Amount			
Randi Leone	Administrator	0%	\$ 14,039	Workers' Compensation Insurance	\$ 5,612	IDPH License Fee		\$ 400			
Marilyn Neiselin	Administrator	0%	1,840	Unemployment Compensation Insurance	7,710	Advertising; Employee Recruitment		441			
Mary Netwemeyer	Administrative	0%	942	FICA Taxes	15,354	Health Care Worker Background Check (Indicate # of checks performed <u>7</u>)		49			
				Employee Health Insurance	8,706	Illinois Health Care Association Dues		927			
				Employee Meals	3,271	Other Dues, Fees & Licenses		611			
				Illinois Municipal Retirement Fund (IMRF)*		Parent Company Allocation		(3)			
				Employee Morale	656						
				Employee Physicals	20						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Ellner Terrace
Provider #: 0036327
07/01/01 to 06/30/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) **868**

Allocated from Residential Services, Inc.

Altschuler, Melvoin & Glasser LLP	Accounting	3,969
Lawrence Manson	Legal	768

Allocated from Parent Company

Altschuler, Melvoin & Glasser LLP	Accounting	399
American Express Tax & Business Services	Accounting	387
Heinold-Banwart	Accounting	678
Lawrence Manson	Legal	890

Total (agree to Schedule V, line 19, column 8) **7,959**

See Accountants' Compilation Report

Center for Residential Management, Inc.
Professional Fees Allocation
June 30, 2002

Detailed legal invoice listing

American Express Tax & Business Services	Accounting	13,626	Lawrence Manson	3,260
Altschuler, Melvoin & Glasser LLP	Accounting	14,178	Lawrence Manson	4,360
Heinold-Banwart	Accounting	24,092	Lawrence Manson	1,300
Lawrence Manson	Legal	31,620	Lawrence Manson	5,600
Amount allocated through CRM allocation		<u>83,516</u>	Lawrence Manson	360
			Lawrence Manson	3,420
			Lawrence Manson	500
			Lawrence Manson	2,540
			Lawrence Manson	1,980
			Lawrence Manson	2,720
			Lawrence Manson	1,700
			Lawrence Manson	<u>3,880</u>
				<u>31,620</u>

	Lakeview	Countryview	Sparta	Ellner	Taylorville	Gateway	Aviston	Briarbrook	Harris	Joshua	Terra	Park Place	Perrine	Okawville	WGarden	Galaxy	Cardinal	BGHill	Troy	CCH 185th	CCH Lee St.	Mt. Vernon	Jeffersonian	Casey	TOTAL
bed days available	52,925	-	5,840	5,840	5,840	-	5,840	5,840	5,840	5,840	5,840	5,840	1,460	2,190	1,460	2,920	-	2,920	1,460	2,190	1,638	23,360	23,725	38,690	207,498
Alloc. Percentage	0.255063	0.000000	0.028145	0.028145	0.028145	0.000000	0.028145	0.028145	0.028145	0.028145	0.028145	0.028145	0.007036	0.010554	0.007036	0.014072	0.000000	0.014072	0.007036	0.010554	0.007894	0.112579	0.114338	0.186460	1.000000
American Express Tax & Business Services	3,512	-	387	387	387	-	387	387	387	387	387	387	83	128	80	176	-	176	80	128	92	1,551	1,575	2,568	13,626
Altschuler, Melvoin & Glasser LLP	3,616	-	399	399	399	-	399	399	399	399	399	399	100	150	100	200	-	200	100	150	112	1,596	1,621	2,644	14,178
Heinold-Banwart	6,145	-	678	678	678	-	678	678	678	678	678	678	170	254	170	339	-	339	170	254	190	2,712	2,755	4,492	24,092
Lawrence Manson	8,065	-	890	890	890	-	890	890	890	890	890	890	222	334	222	445	-	445	222	334	250	3,560	3,615	5,896	31,620
	<u>21,339</u>	<u>-</u>	<u>2,354</u>	<u>2,354</u>	<u>2,354</u>	<u>-</u>	<u>2,354</u>	<u>2,354</u>	<u>2,354</u>	<u>2,354</u>	<u>2,354</u>	<u>2,354</u>	<u>575</u>	<u>865</u>	<u>572</u>	<u>1,159</u>	<u>-</u>	<u>1,159</u>	<u>572</u>	<u>865</u>	<u>643</u>	<u>9,419</u>	<u>9,566</u>	<u>15,599</u>	<u>83,516</u>

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2		N/A											
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace

STATE OF ILLINOIS

0036327

Report Period Beginning: 07/01/01

Page 23

Ending: 06/30/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$927
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 31,348
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

See attached Schedule 23B

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 3,271 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 74%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Altschuler, Melvoin & Glasser LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Ellner Terrace
Provider #0036327
RSD Salaries Allocation
06/30/02

Ellner

Name of RSD	Number of Residents	X	Number of Hours Req'd	X	Weeks per year	=	Total Hours	/	Total hours paid	X	Total RSD Wages per Trial Balance	=	Total Reclassified to RSD (In 10)	Total Remaining in Administrative Salaries (In 17)
Mary Net.	15		2		52		1,560		1,630		21,924		20,982	942

Rule 350.3740 requires a minimum Resident Services Coordinator staffing of two hours per week per resident. We allocated wages between the Nursing/Programs section of the cost report with the remainder left in Administrative.

See Accountants' Compilation Report

RECONCILIATION REPORT

Ellner Terrace

02:42 PM 11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-105,022	equal to	-105,022	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	2,629	equal to	2,629	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	4,975	equal to	4,975	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	69,255	equal to	69,255	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,886	equal to	2,886	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	9,605	equal to	9,605	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	64	equal to	64	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	444	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	74,777	equal to	74,777	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	175,577	equal to	175,577	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	127,358	equal to	127,358	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	77,411	equal to	77,411	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	146,760	equal to	146,760	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	22,943	equal to	22,943	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	148,771	equal to	148,771	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	3,100	< or = to	3,100	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to	0	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to	0	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	16,429	equal to	16,429	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	9,943	equal to	9,943	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to	0	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to	0	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	16,821	equal to	16,821	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to	0	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	195,064	equal to	195,064	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,987	< or = to	2,002	-15	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	1,200	< or = to	1,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	123	< or = to	2,688	-2,565	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,531	< or = to	2,531	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	16,821	equal to	16,821	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	68,400	equal to	68,400	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	868	equal to	868	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	41,329	equal to	41,329	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	2,425	equal to	2,425	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,993	equal to	2,993	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	31,348	equal to	22,943	8,405	FAILED	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	3,271	< or = to	14,553	-11,282	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	3,271	equal to	3,271	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	3,100	equal to	3,100	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	41,768	equal to	41,768	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	9,518	equal to	9,518	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	0	equal to	0	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	16,370	equal to	16,370	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	38,089	equal to	38,089	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	21,513	equal to	21,513	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	258,448	equal to	258,448	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	81,052	equal to	81,052	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	355,692	equal to	355,692	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	16,429	1,118	2,002	19,549	0	19,549	0	19,549
2. Food P	0	25,541	0	25,541	0	25,541	-3,271	22,270
3. Housek	0	1,427	0	1,427	0	1,427	0	1,427
4. Laundry	0	1,686	0	1,686	0	1,686	0	1,686
5. Heat ar	0	0	9,669	9,669	0	9,669	0	9,669
6. Mainte	9,943	0	6,962	16,905	0	16,905	0	16,905
7. Other (	0	0	0	0	0	0	0	0
8. Total G	26,372	29,772	18,633	74,777	0	74,777	-3,271	71,506
9. Medical	0	0	1,200	1,200	0	1,200	0	1,200
10. Nursin	148,771	3,722	2,688	155,181	0	155,181	0	155,181
10a. Ther	0	0	64	64	0	64	0	64
11. Activi	0	3,472	0	3,472	0	3,472	0	3,472
12. Social	0	0	2,531	2,531	0	2,531	0	2,531
13. Nurse	3,100	0	6,505	9,605	0	9,605	0	9,605
14. Progr	0	0	2,331	2,331	0	2,331	0	2,331
15. Other	0	0	1,193	1,193	0	1,193	0	1,193
16. Total I	151,871	7,194	16,512	175,577	0	175,577	0	175,577
17. Admin	16,821	0	68,400	85,221	0	85,221	0	85,221
18. Direct	0	0	0	0	0	0	2,959	2,959
19. Profes	0	0	868	868	0	868	7,091	7,959
20. Fees,	0	0	2,310	2,310	0	2,310	115	2,425
21. Cleric	0	1,813	6,495	8,308	0	8,308	3,199	11,507
22. Emplo	0	0	26,776	26,776	0	26,776	14,553	41,329
23. Inserv	0	0	454	454	0	454	0	454
24. Travel	0	0	2,718	2,718	0	2,718	275	2,993
25. Other	0	0	562	562	0	562	253	815
26. Insura	0	0	141	141	0	141	4,598	4,739
27. Other	0	0	0	0	0	0	0	0
28. Total C	16,821	1,813	108,724	127,358	0	127,358	33,043	160,401
29. Total C	195,064	38,779	143,869	377,712	0	377,712	29,772	407,484
30. Depre	0	0	4,716	4,716	0	4,716	259	4,975
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	565	565	0	565	2,064	2,629
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	69,255	69,255	0	69,255	0	69,255
35. Rent -	0	0	2,875	2,875	0	2,875	11	2,886
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	77,411	77,411	0	77,411	2,334	79,745
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	0	783	783	0	783	444	1,227
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	22,943	22,943	0	22,943	8,405	31,348
43. Other	0	0	145,977	145,977	0	145,977	-145,977	0
44. Total S	0	0	169,703	169,703	0	169,703	-137,128	32,575
45. Grand	195,064	38,779	390,983	624,826	0	624,826	-105,022	519,804

	After	
	Operating Consolidation	
General Service Cost Center		
1. Cash on	6,045	6,045
2. Cash - F	0	0
3. Account	138,532	138,532
4. Supply I	0	0
5. Short-T	0	0
6. Prepaid	1,275	1,275
7. Other Pi	5,109	5,109
8. Account	113,665	113,665
9. Other (s	58,120	58,120
10. Total c	322,746	322,746
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	0
14. Buildin	0	0
15. Lease	16,370	16,370
16. Equipn	38,089	38,089
17. Accum	-21,513	-21,513
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	0
23. other (:	0	0
24. Total L	32,946	32,946
25. Total A	355,692	355,692
CURRENT LIABILITIES		
26. Accour	19,306	19,306
27. Officer	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	12,891	12,891
31. Accrue	0	0
32. Accrue	0	0
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other (	55,529	55,529
37. Other (	0	0
38. Total C	87,726	87,726
LONG TERM LIABILITES		
39. Long-T	9,518	9,518
40. Mortga	0	0
41. Bonds I	0	0
42. Deferre	0	0
43. Other L	0	0
44. Other L	0	0
45. Total L	9,518	9,518
46. Total Li	97,244	97,244
47. Total Ei	258,448	258,448
48. Total Li	355,692	355,692

	Balance per	
	Medicaid	
	Trial Balance	
1. Gross F	558,314	
2. Discour	0	
Subtota	558,314	
4. Day Ca	0	
5. Other C	0	
6. Therap	0	
7. Oxygen	0	
Subtota-		
9. Paymer	143,172	
10. Other	0	
11. Nurse	4,344	
12. Gift an	0	
13. Barbei	0	
14. Non-P	0	
15. Teleph	0	
16. Rental	0	
17. Sale o	0	
18. Sale o	0	
19. Labor	0	
20. Radiol	0	
21. Other	0	
22. Laund	0	
Subtot	147,516	
24. Contril	0	
25. Intere	48	
Subtot	48	
27. Other	0	
28. Other	0	
Subtot-		
30. Total F	705,878	
31. Gener	680,120	
32. Health	1,154,988	
33. Gener	668,561	
34. Owner	144,710	
35. Specie	60,174	
35. Provid	41,063	
37. Other	0	
40. Total E	2,749,616	
41. Incom	#####	
42. Incom	0	
43. Net In	#####	

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9 Line 16 for mortgage insurance.

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